Maryland Health Benefit Exchange
Financial Sustainability Advisory Committee

Meeting #2

October 17, 2011

Agenda

- Exchange Cost Estimates
- Exchange Financing Options Overview
- Financing Background Information

Cost Estimate Overview

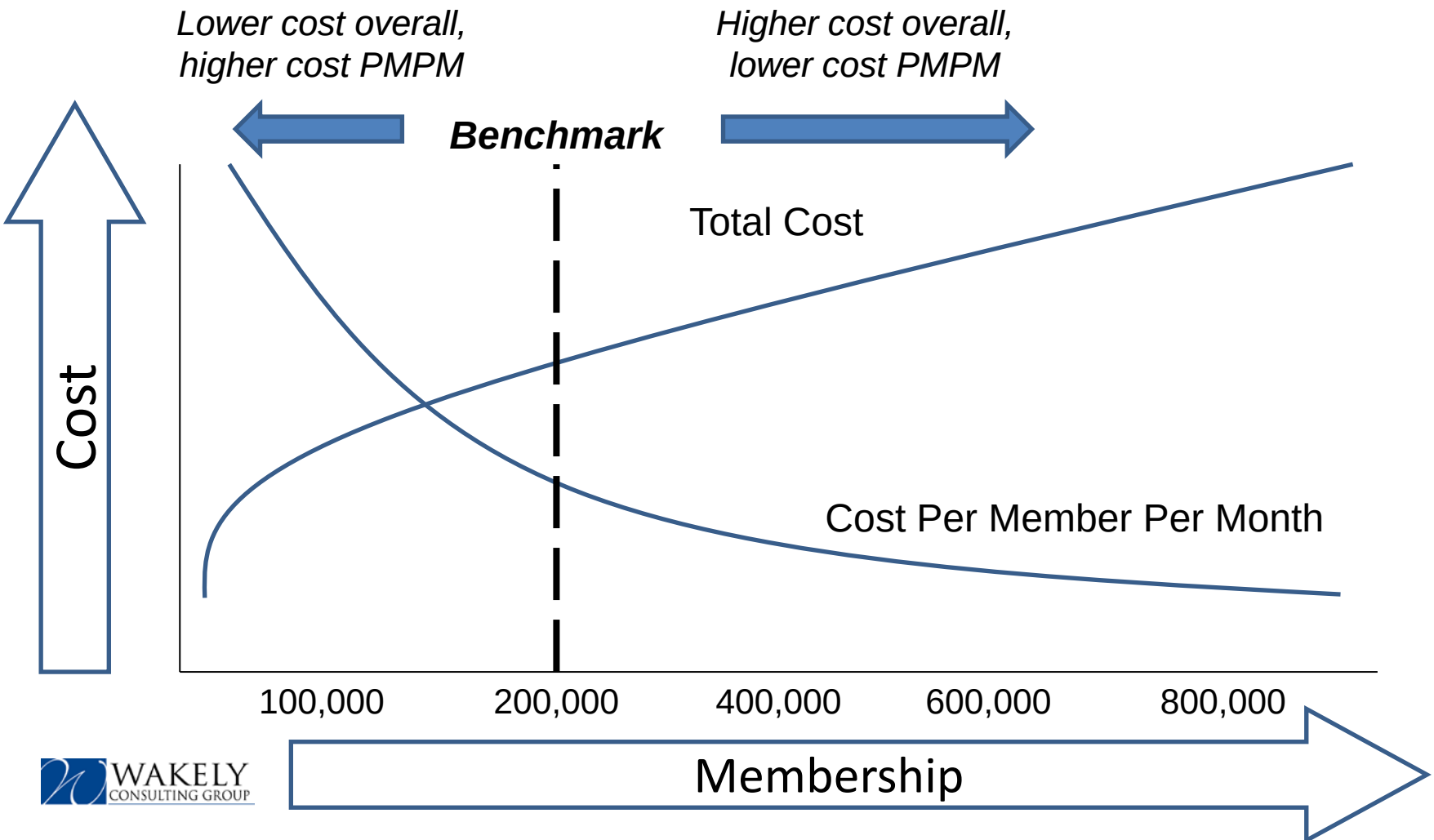
- Estimating exchange operating costs is challenging as there are limited examples currently in the market, and a number of policy decisions are not yet finalized
- Several estimation methods exist:
  - Estimate expenses “bottom up” (granular build up)
  - Use existing benchmark, adjusted for state-specific market
  - Expenses constrained by revenue yield (“top down”)
- For this study, we relied primarily on the second method, but also discuss the third
  - In practice, the revenue stream, once set, will dictate overall expense limits

Benchmark Methodology

- Benchmark based on fully operational exchange with approximately 200,000 members
  - ~50 FTEs, highly outsourced model, and annual budget of roughly $30M
  - Closest existing comparison to ACA exchange
- Benchmark adjusted for:
  - Additional requirements of ACA (e.g., risk adjustment, navigators)
  - Key variables unique to Maryland (e.g., enrollment, premium levels, cost of living)

Benchmark Methodology (Cont.)

Exchange expenses are scalable based on enrollment and the relationship between fixed and variable costs.



Key Assumptions and Scenarios

- Key Data Assumptions
  - FTE totals and systems cost based on benchmark methodology, adjusted for enrollment range
  - Medical trend, salary level, enrollment size and source Maryland-specific
- Key Variables for Scenario Analyses
  - BHP (Yes/No)
  - ACA impact on premium (Low/Moderate/High)
  - Enrollment volume (Low/Moderate/High)

Range of Total Cost Estimates

Without Basic Health Plan

	2014		2015		**2016**	
	Low	High	Low	High	**Low**	**High**
YE Members	160,246	273,113	216,679	442,412	**290,415**	**525,201**
Total Costs	$25M	$31M	$38M	$51M	**$44M**	**$61M**
PMPM Costs	$21.20	$15.36	$16.82	$11.86	**$13.92**	**$10.28**
Producer Comp.*	$4M	$8M	$9M	$18M	**$13M**	**$25M**
PMPM Prod.	$3.90	$4.04	$3.99	$4.12	**$4.01**	**$4.17**

With Basic Health Plan

	2014		2015		**2016**	
	Low	High	Low	High	**Low**	**High**
YE Members	85,915	161,616	123,766	275,167	**169,627**	**348,665**
Total Costs	$21M	$25M	$32M	$43M	**$36M**	**$51M**
PMPM Costs	$32.83	$21.06	$25.19	$16.22	**$19.65**	**$13.05**
Producer Comp.	$3M	$5M	$5M	$12M	**$8M**	**$17M**
PMPM Prod.	$4.06	$4.27	$4.20	$4.36	**$4.22**	**$4.42**

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** Producer compensation highly uncertain based on share of enrollment utilizing brokers, relationship structure, and compensation level..*

Expenses as % of QHP Premium, 2016

- *Estimates presented here are based on the adjusted benchmark and multiple assumptions drawn from market research*
- *In practice, the exchange will manage its expense line to fit within revenue requirements*

BHP Scenario	ACA Impact Scenario	Enrollment Scenario		
		High	Moderate	Low
With BHP	Low	3.5%	4.2%	5.4%
	Moderate	3.2%	3.9%	5.1%
	High	2.8%	3.4%	4.3%
Without BHP	Low	2.9%	3.3%	4.0%
	Moderate	2.7%	3.1%	3.7%
	High	2.2%	2.6%	3.1%

Under 3% 3% - 4% 4% and Above

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** Figures do not include broker or producer compensation.*

Alternate Expense Estimate Model

Once a revenue stream is established, whether QHP-based or broad-based, the exchange will manage finances within that revenue target or be forced to increase revenue source.

Mid-point Premium Estimate, 2016	*$1,246 M*

Revenue Yield Based on % QHP Assessment	
2%	$25 M
3%	$37 M
4%	$50 M
5%	$62 M
6%	$75 M

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Key Questions

- What are the user fees, licensing fees, or other assessments that should be imposed by the Exchange to fund its operations?
- What methodology would be appropriate to ensure that the income of the Exchange comports with the expenditures of the Exchange, and is both fair and efficacious?
- What methodology will best mitigate the risk of a revenue shortfall?

Key Questions (Cont.)

- Should the financing source be narrowly applied or broad-based?
- What criteria should the Board use to determine an appropriate funding source?

Assessment on QHP enrollment through exchange	QHP Enrollment inside and outside exchange	Other affected market participants (hospitals/carriers)	Other Broad- based Assessment

The Exchange is a business; enrollees and QHP's are its "customers" and "clients"

The Exchange provides a public service; its funding should be spread broadly

Financing Options

- QHP user fee for participating health plans
- Broad-based assessment
  - Targeted to meet spending need (as used for MHCC, MIA)
  - Tied to market metric (used for MHIP assessment)
    - Carrier premium revenue (fully insured and/or self-insured)
    - Hospital revenue
- Opportunities from dynamics of health care reform (alterations to existing revenue, uses of funds)
- Other Revenue Sources
  - "Sin" tax, licensure/user fees, web-based advertising

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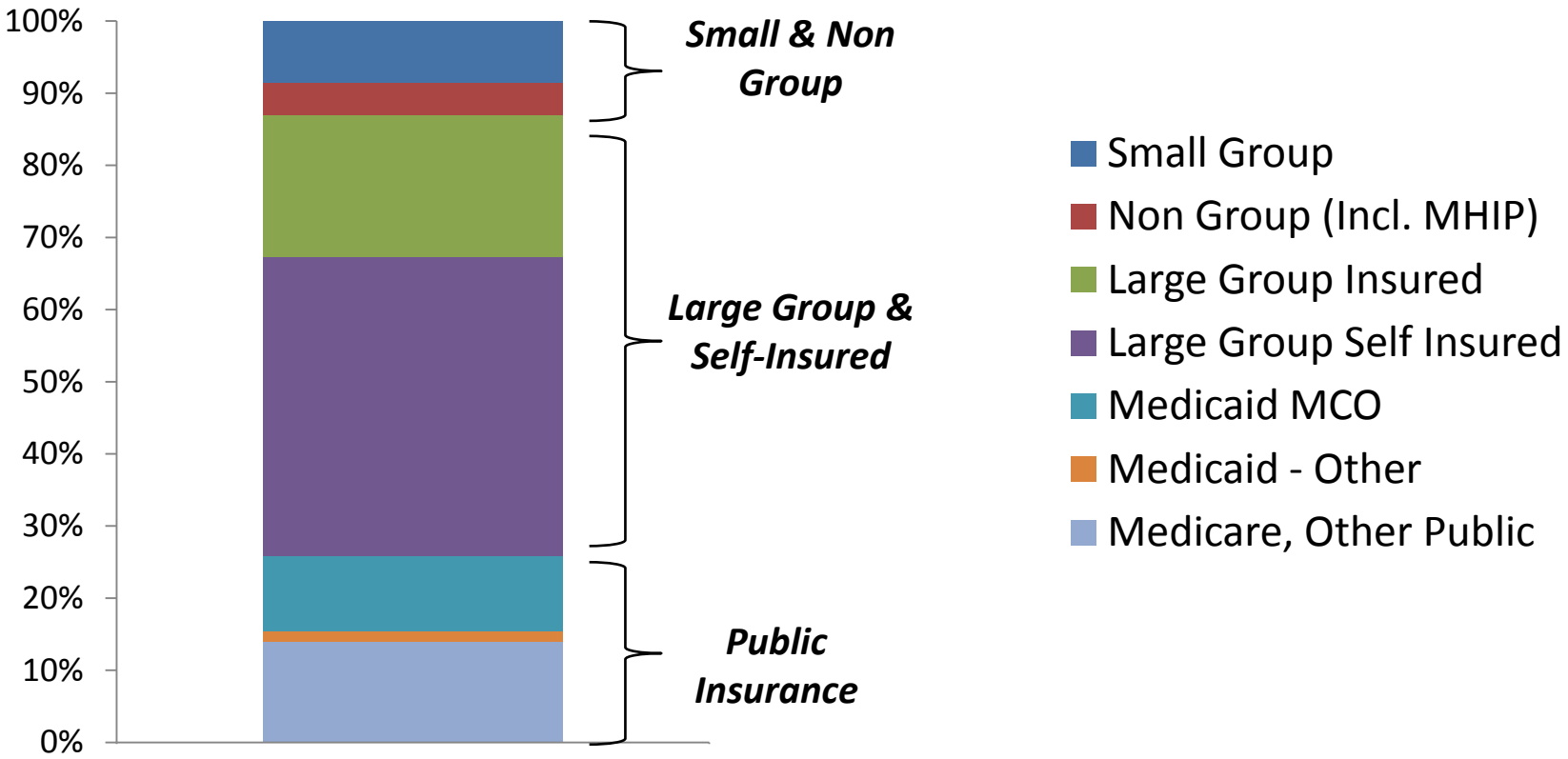
Market Share by Payer Type

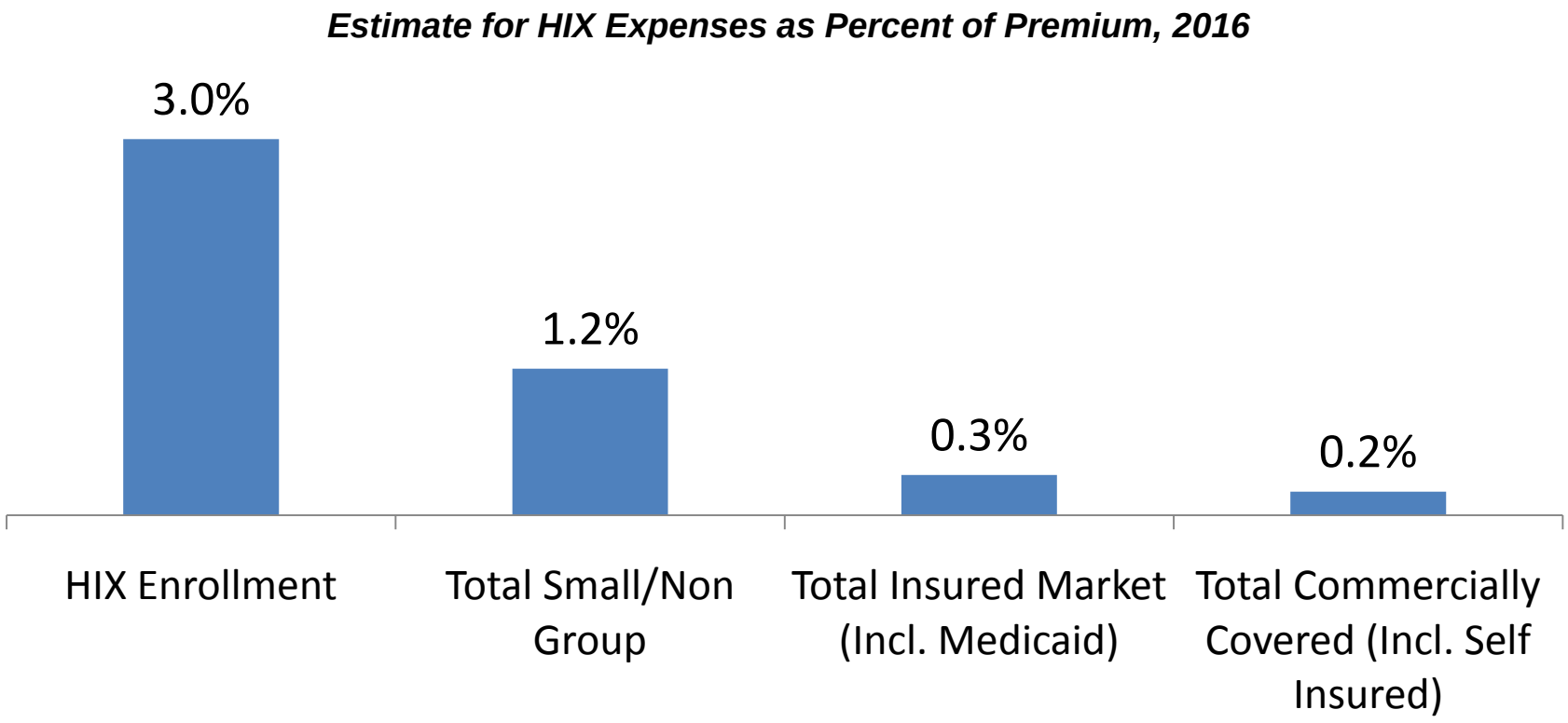
- *Small/Non-group account for 17% of commercial covered lives (13% of total)*
- *Large group and self-insured account for 83% of commercial covered lives (61% of total)*



Source: "Market Rules and Adverse Selection: A Background Paper", The Hilltop Institute, 2011.

Funding Base Expansion

Spreading the assessment across a larger book of business will reduce the level of assessment required to raise the same funding level



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Source for Denominators: Maryland Insurance Administration, 2010.

Hospital Rate Setting

- All payer rate setting allows Maryland to use hospital rate assessment to capture revenue from a broad-base of stakeholders
  - Currently used to fund MHIP, support Medicaid
- By including some or all of assessment value in regulated rates and then assessing revenue, state captures revenue from all payers

QHP Assessment Mechanics

- Carriers are required to apply the same pricing inside and outside the exchange for the small and non-group markets
- QHP assessments may be collected from carriers and invisible to enrollees
- Any price impact from the assessment will be spread across entire small/non-group book

Existing Health Care Assessments

Assessment	Assessment Base	Use of Funds	Mechanism / Method	Approximate Value
1. Insurance Premium Tax	Fully Insured and Medicaid MCO	Rate stabilization fund; Medicaid	2% of Net Premium	$378M
2. MIA Assessment	All carriers ; fully insured only	MIA Operating Expenses	Targeted to fund agency expenses	$11M*
3. HSCRC Assessment	Hospital revenue	HSCRC Operating expenses	Targeted to fund agency expenses	$5M
4. MHCC Assessment	Hospitals, Carriers, Nursing Homes	MHCC Operating Expenses	Targeted to fund agency expenses	$27M
5. UCC Assessment	Hospital revenue	Funds hospital uncompensated care	Targeted to fund UCC	$1,000M
6. MHIP (High Risk Pool) Surcharge	Hospital revenue	Subsidizes High Risk Pool Premiums	Percent of hospital revenue (.8 - 3%)	$104M**

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* Total assessment 28M; health portion is $11M

** CareFirst also contributes $17M to support Rx Subsidy Program

Financing Options Discussion Points

	QHP Assessment	Broad Based Assessment	Other Revenue Options
Breadth of Funding Source	Spreads cost across entire Non/Small group market (premiums must remain same in/outside HIX)	Most broadly defined; lowest required assessment rate	Can be broad ("sin tax") or highly focused (advertising)
Member/Market Impact	Cost difference invisible to enrollees, but impact limited to SG/NG markets	Minimizes impact on small, non-group premiums	Can capture revenue external to health system
Impact of Enrollment Scale	At low enrollment, small impact to carrier when spread across total book; may create incentive to sell outside exchange if high gradient b/w and outside	At low enrollment less difficult to raise needed funding from existing revenue sources; high enrollment will require greater impact on total market	At low enrollment easier to raise funds from alternate revenue source; larger enrollment scale will make advertising more viable option

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